UTILIZATION MANAGEMENT FOR ADULT MEMBERS

Executive Summary & Analysis by Level of Care

Quarters 1 & 2 of 2018: January-June 2018 - Submitted September 4, 2018

Connecticut BHP
Supporting Health and Recovery

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Connecticut BHP
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UTILIZATION REPORT FOR ADULT MEMBERS

Quarters 1 & 2 of 2018: January-June 2018

Reports

General Overview

On at least a semiannual basis, the reports mutually agreed upon in Exhibit E of the CT BHP contract are submitted to the State for review. The shift to semiannual reports was designed to minimize noise created by quarter-to-quarter fluctuations that do not reflect a true trend in the data. The March deliverable serves as the annual report and covers four consecutive years of utilization data. The September deliverable covers 10 consecutive quarters with a focused analysis on the two most recent quarters, but may include the past four if there is information necessary to review that had not been analyzed previously.

This report focuses on the utilization management portion of these reports, evidenced in the 4A series, which reviews utilization statistics such as admissions per 1,000 members (Admits/1,000), days per 1,000 members (Days/1,000), and average length of stay (ALOS).

Within this interactive report, all utilization data is available via drop-down filters, but the narrative highlights the areas of interest related to certain utilization trends. In some cases, demographic breakouts are available to enhance the understanding of utilization. Additionally, the narrative identifies the underlying factors, which drive the trends and associated programmatic responses taken by Beacon Health Options to impact/mitigate or support the trend. Beacon also presents recommendations to address remaining challenges and reports progress related to these planned recommendations. The areas of focus for this deliverable are listed on the following page.

Methodology

The data contained in this report are based on authorization admissions and are refreshed for each subsequent set of updates during the year. Due to changes in eligibility, the results for each quarter or year may change from the previously reported values. The reports and analyses for all levels of care are affected by this change. Please note that utilization metrics may change with the refresh of the data. Therefore, the reader should be cautious when interpreting the latest quarter of data. The contractor will monitor the post-refresh changes closely. If warranted, methodology will be revisited.

The methodology for membership totals remains unchanged. For the Total Membership counts, each member is only counted once per quarter, even if he/she changes eligibility groups or experiences gaps in eligibility. For instance, if a member changes benefit groups within the quarter, that member is included in the totals for each benefit group, but only once for the total membership. This methodology is referred to in the graphs as “Unique Membership”. For the benefit groups, members are counted in each group in which they were eligible during the time period (quarter or year). This means that the individual benefit group membership counts cannot be added to obtain an overall total, since members can shift between benefit groups.

The methodology for calculating age has changed, resulting in a slight shift in adult and youth membership totals. Previous to this report, counts for adults and youth were based on if a member met that age criteria during the time period. This meant that youth who were both 17 and 18 years old in a quarter were counted in both the adult and youth totals. In order to allow for the drill-down of demographic and age information, it was required that members be counted in only one group during a time period. Age group is now based on the age that a member was for the majority of the time period (quarter or year). Other demographics such as gender and race/ethnicity are based on the most recently updated eligibility. These demographics will update as needed as we want to report on the most accurate gender or race/ethnicity that a member identifies with.

Additionally, while unchanged from previous reporting periods, it is worth noting that the per 1,000 measures compare the utilization rates of the population to the population’s “member months”. This means that when viewing the Admits/1,000 of HUSKY D members the rate is based on the number of admissions within the HUSKY D population, not the entire adult population. This helps to analyze which populations are potentially more chronic, acute, or in need.

EXECUTIVE SUMMARY REPORT FOR ADULT MEMBERS

Quarters 1 & 2 of 2018: January-June 2018

Total Membership

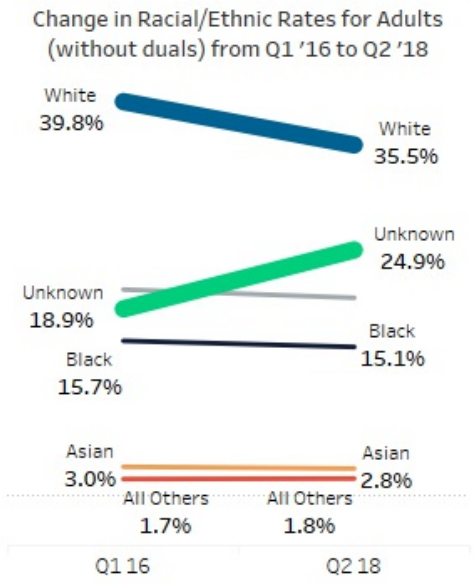
Connecticut Medicaid membership has remained stable for the past two-and-a-half years, with a quarterly change of no more than 2% over ten quarters. Membership (all members including those dually eligible) was stable the first two quarters of 2018 (873,499 and 869,402, respectively). Adult members continue to account for 62% of the total Medicaid membership including duals.

Adult membership including duals has been relatively stable the past two years, increasing by 17,487 members since Q2 '16. There was a 0.2% reduction in membership in Q1 '18 compared to the prior quarter, followed by an additional 0.4% reduction in Q2 '18 to 543,316 adult members. This was driven by a reduction in members that had dual eligibility. The total members without duals increased by 1,620 members from Q1 to Q2 '18 to 490,269 members.

Membership Demographics

Despite slight increases or decreases in the total number of members, demographic rates for gender and age have been stable, which means that members coming in or out of Medicaid are not from any particular demographic subgroup, but from all. Consistent across the past 10 quarters, the adults without dual population continues to be approximately 56% female and 44% male. Age groups also have remained consistent across the quarters. Most (27%) of the adult Medicaid members without duals are ages 25-34, which is consistent with previous years. The next two largest groups are the 35-44 and 18-24 year-old groups; each are approximately 19% of the adult population without duals.

There have been changes in the racial/ethnic breakdown of the Medicaid adults without duals population. As mentioned in the CY 2017 deliverable, in 2016 changes were made to the ImpaCT system, the Department of Social Service's (DSS) advanced eligibility system used to manage Medicaid members' eligibility. More specifically, updates to racial and ethnic options caused a significant increase in the overall volume of members classified as "Unknown." There is not an option for Unknown in the eligibility system, so while the increase in the Unknown population could be due to members not selecting a race or ethnic category, Beacon plans to investigate other possible causes for the increase.



Since the implementation of the new system, the number of adult members identifying as White has been decreasing while the number of members classified as Unknown has increased. In Q4 '17, the White population increased for the first time after six (6) quarters of a steady decline. The population of adult White members was then stable for the past two quarters in 2018. Members ages 55 and older contributed 62% to this increase in the White population. Currently, approximately 36% of the adults without duals population are White and 25% are Unknown. A dramatic shift has occurred over time in only these two groups, as the population identifying as White has decreased at almost the same rate that the population identifying as Unknown has increased. Hispanic adults are 20% of the population, followed by Black adults at 15%, Asian adults at less than 3%, and adults of other races/ethnicities at less than 2%–all of which have maintained a constant percentage of the population over the past 10 quarters.

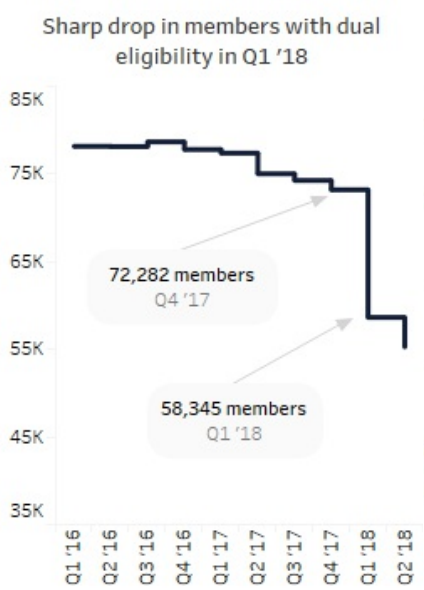
Benefit Membership

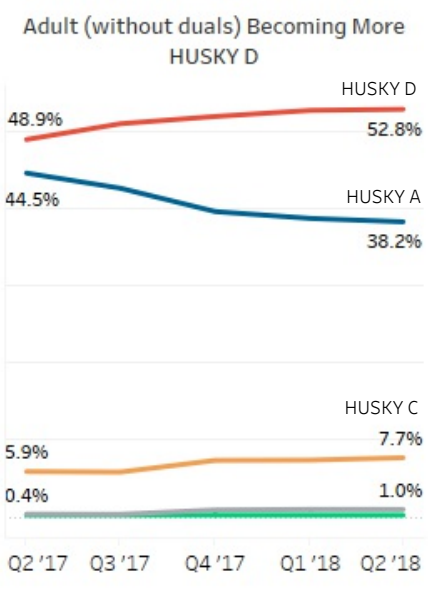
HUSKY D continued to be the largest Medicaid benefit group for adult members, followed by HUSKY A. However, HUSKY D's population has increased more dramatically in the past four (4) quarters, going from 51% of the population (excluding duals) in Q3 '17 (242,390 members) to almost 53% of the population (260,788 members) in Q2 '18. HUSKY A has decreased over the same time-period, going from 43% (202,646 members) in Q1 '17 to 38% (188,825 members) in Q2 '18. HUSKY C (ABD) also saw an increase from 6% of the population (27,798 members) in Q2 '17 up to almost 8% (37,993 members) in Q2 '18.

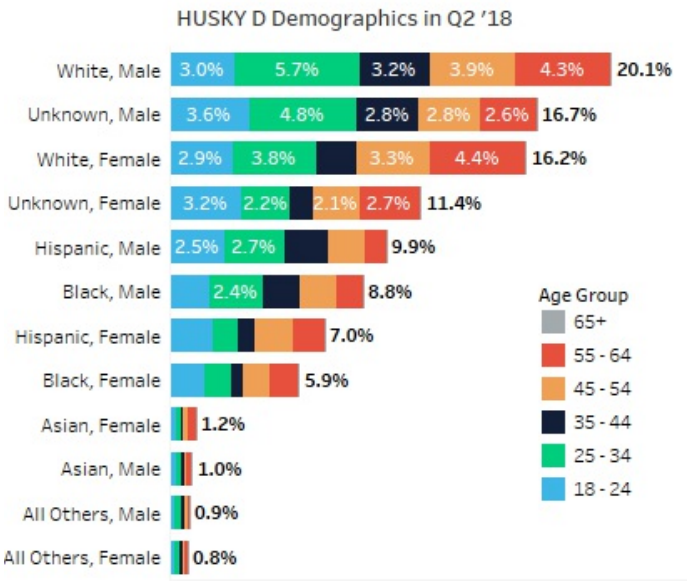
Beacon is aware of changes to the HUSKY A eligibility criteria that began on January 1, 2018 when the income limit was lowered from 155% to 138% of the Federal Poverty Level. This change was reversed starting July 1, 2018, so members who lost coverage during Q1 and Q2 of 2018 for HUSKY A may gain coverage back in Q3 '18. Within the recent reduction in HUSKY A members, the largest decline was within the White population, which had a reduction of almost 4% in Q1 '18, (down 2,194 members). The other racial/ethnic groups also experienced a reduction, but less so (around 1 or 2% each).

The number of members with dual eligibility had a sharp 20% decline from Q4 '17 (73,207 members) to Q1 '18 (a reduction of 14,568 members to 58,639). Dual eligibility membership decreased again in Q2 '18 to 55,284 members (a 5.7% drop). Over 68% of the decline in dual membership was from the HUSKY C (ABD Dual) group; however, HUSKY A Dual and HUSKY C (LTC Dual) also saw reductions. Beacon is uncertain of the cause for this decline in dual eligibility and will engage with State Partners on eligibility criteria or other possible contributing factors.

HUSKY D is the largest single benefit group, and continues to be primarily White males (20%), followed by Unknown males (17%), White females (16%), and Unknown females (11%). Please reference the bar chart for additional information on race, gender, and age for HUSKY D members.



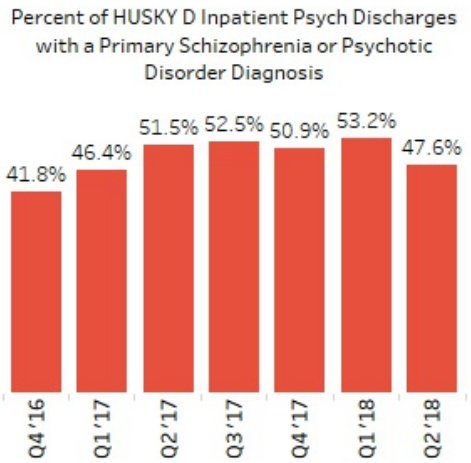




Inpatient Psychiatric Hospital Utilization

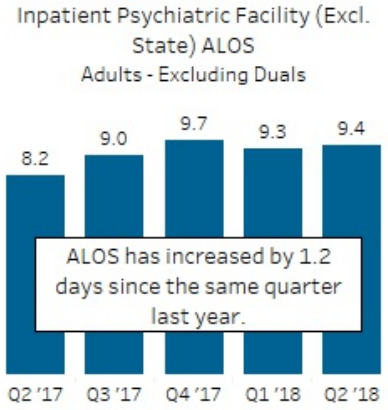
Annual discharge volume from inpatient psychiatric hospitals (in and out-of-state, but excluding State facilities) had been stable from 2015-2017 at approximately 10,600 discharges a year for all members without duals. There were 5,246 discharges in the first two quarters of 2018, which is similar to trends from prior quarters and years. Discharge volume increased 7% from Q1 to Q2 '18, which was consistent with seasonal fluctuations in inpatient psychiatric utilization with a peak in the second quarter (spring) and a low in the fourth quarter (winter).

In Q1 and Q2 '18, for non-dual members, 69% of all inpatient psychiatric discharges had HUSKY D coverage, followed by HUSKY A (16%) and HUSKY C (15%). The volume of HUSKY D discharges is disproportionate to their population percent, which was 53% in Q2 '18. Conversely, while HUSKY D discharges have increased, the volume of HUSKY A discharges has been decreasing since Q2 '17. In fact, over the past five (5) quarters, the proportion of discharges that are HUSKY D has increased 11 percentage points (58% to 69%), while their total membership rate has only increased 4 percentage points (49% to 53%). HUSKY A's inpatient discharge proportion has decreased 10 percentage points (26% to 16%), while their membership rate decreased 7 percentage points (45% to 38%). This indicates that the increase in HUSKY D inpatient psychiatric discharge volume is not solely attributed to the increase in HUSKY D membership, but rather a change in the severity of the membership as evidenced by an increase in the percent of HUSKY D members with a primary schizophrenic or psychotic disorder than in quarters past. Discharge volume of the other benefit groups has been flat.



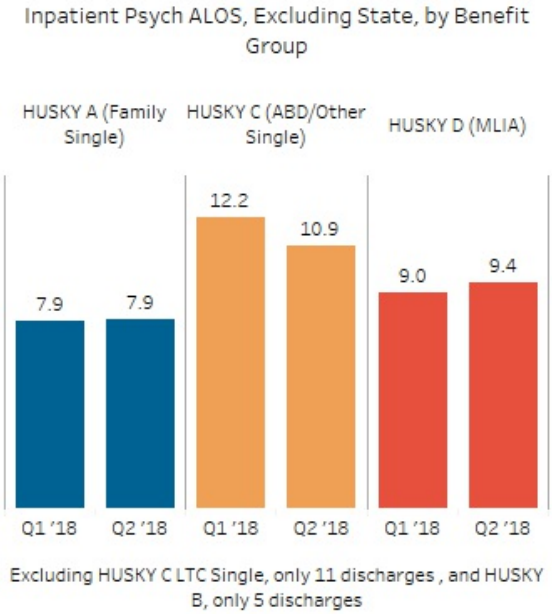
White members continue to have the highest percentage of inpatient psychiatric discharges of all racial/ethnic groups, at 41% of discharges in Q2 '18. White members had disproportionate utilization in this level of care, since they represent 36% of the Medicaid adult population without duals. Hispanic members, on the other hand, are under-represented – they account for 16% of inpatient discharges, but 20% of the adult population. Black members had proportional utilization at both 15% of the discharges and the adult population. All other demographic trends remain consistent over the quarters: Adults ages 25-34 have the largest share of discharges (29%); Males are the majority at 54%.

After the average length of stay (ALOS) reached a high of 9.7 days in Q4 '17, it decreased by 3.7% (0.4 days) to 9.3 days in Q1 '18 and remained stable in Q2 '18 at 9.4 days. Despite the decrease, the last three quarters are still the three highest out of the past 10 quarters. There has also been a steady increase in the acute length of stay (removing the days that a member is waiting for a state hospital bed) from 7.9 days in Q2 '17 to 8.9 days in Q2 '18.



Those members with a primary diagnosis of schizophrenia/psychotic disorder (a little over 25% of the inpatient population) increased the statewide ALOS by 3.2 days and their ALOS has been trending up over the last 10 quarters. While the average days in overstay had decreased since Q3 '17, when it hit a high of 47.4 days, down to 40 days in Q2 '18, there were 1,208 overstay days (for 32 people) in Q2 '18 – the highest to in the last 10 quarters. The average days in overstay has also been trending up over the quarters and most recently was 34.8 days in Q1 '18 and 40 days in Q2 '18 (591 total days and 1,208 total days, respectively).

While there was almost no difference in the ALOS by gender, there were differences in benefit groups, race/ethnicity, and age groups. Consistent with prior quarters, the HUSKY C population continues to have the longest ALOS. This is consistent with the composition of the HUSKY C population based on eligibility criteria, as HUSKY C tends to be an older population with more chronic conditions. HUSKY D has the next highest ALOS, which is relatively similar to the overall ALOS – 9.0 days in Q1 '18 and 9.4 days in Q2 '18. Due to the decrease in HUSKY A members and increase in HUSKY D members using inpatient psychiatric treatment, it is possible that this shift in membership and acuity has impacted the overall increase in ALOS in recent quarters. In fact, over the past year, the HUSKY D population's ALOS has increased by slightly over a day from 8.3 days in Q2 '17 to 9.4 days in Q2 '18.



Despite the small volume, Asian adults have a much longer length of stay than any other racial or ethnic population (15.5 days in Q1 '18 and 12.1 days in Q2 '18). Beacon surmises that because Asian members are under-represented in behavioral health utilization, this population utilizes inpatient psychiatric treatment less frequently due to cultural beliefs and may not have had any prior treatment services resulting in a longer length of stay initially in order to achieve stabilization.

There is approximately a two-day spread between the "All Others" group (comprised of Native Americans, Pacific Islander, and Multi-racial members) which had the lowest ALOS in the first two quarters of 2018 (7.3 days and 6.9 days, respectively), and White members, who had the longest ALOS (9.4 days and 9.7 days, respectively) behind the much smaller group of Asian members.

Consistent with prior quarters, the two oldest (55-64 and 65+) age groups had the longest inpatient stays for psychiatric treatment, likely due to various factors including age-related medical comorbidities and overall duration of psychiatric diagnoses. The 18-24 year olds, the young adult population, have had the next highest ALOS for eight (8) out of the last 10 quarters, peaking at 9.9 days in Q1 '18 and 9.7 days in Q2 '18. Within the young adult population, Members aged 20-24 drove the high length of stay, not the emerging adults aged 18 and 19.

Discharge volume for in-state PAR hospitals, which excludes the Hospital for Special Care, Prospect Rockville Hospital's eating disorder unit, Natchaug Hospital, and Sharon Hospital, was 2,448 members in Q1 '18 and 2,614 in Q2 '18. Over 37% of discharges in the most recent quarter were at three large facilities: Hartford Hospital, St. Vincent's Hospital, and Yale New Haven Hospital. Johnson Memorial Hospital, Waterbury Hospital, William Backus Hospital, and State of Connecticut – John Dempsey Hospital all had a 25% or more increase in discharge volume from Q1 '18 to Q2 '18. Waterbury Hospital closed their adolescent beds and shifted them to adults, thus contributing to their increased capacity.

The average length of stay in Q1 '18 for in-state PAR hospitals was 9.2 days and ranged from 5.2 days at Charlotte Hungerford to 11.8 days at Prospect Waterbury Hospital. In Q2 '18, the ALOS for these hospitals was 9.4 days and ranged from 5.1 days at Norwalk Hospital to 16.5 at Hospital of Central CT. The four providers with the longest length of stay were consistent from Q1 to Q2 '18: Yale New Haven Hospital (11.4 days, 12.7 days), Hartford Hospital (11.8 days, 11.3 days), Prospect Waterbury Hospital (11.8 days, 10.8 days), Hospital of Central CT (11.7 days, 16.5 days).

Per the data shared with providers as part of the Provider Analysis and Reporting (PAR) Program, the 7-day readmission rates increased slightly in Q1 and Q2 '18 to 5.4%, which is still in range from prior semiannual analyses. The 30-day readmission rate for Q1 and Q2 '18 was 15.9%, which was up one percentage point from 14.9% during Q3 and Q4 '17. Three of the four providers mentioned above with the longest ALOS during the past two quarters had lower than average 7 and 30-day readmission rates. Waterbury Hospital was the only provider with both high ALOS and high readmission rates.

Inpatient Intermediate Duration (IDA) beds at St. Vincent's Hospital are an alternative to a state hospital bed for members who need longer treatment and stability, but likely can return to the community. There were 29 discharges from St. Vincent's IDA unit in 2017 and 14 thus far in Q1 and Q2 '18 combined. The ALOS for CY 2017 was 36.8 days, and in the first half of 2018, the ALOS at for IDA was 35 days (36.1 in Q1 and 33.5 in Q2).

With the number of discharges and the admits/1,000 being stable over time, one would anticipate that the ALOS would be flat as well, but it has not been the case. The ALOS and the days/1,000 have increased over the last several quarters. In order to better understand this increase, Beacon evaluated the inpatient population and noted several changes to the population and the impact that these changes are having on these metrics. More HUSKY D members have been accessing inpatient psychiatric treatment, and this group tend to be sicker as evidenced by their disproportionality in inpatient discharges as compared to their rates within the Medicaid population. HUSKY D members are more significantly impacted by social determinants of health, like barriers to housing, which can impact mental health. HUSKY A members, the next highest membership of the Medicaid inpatient population, traditionally had shorter lengths of stay. If the HUSKY A membership increases following the changes in the eligibility criteria made July 1, 2018 and individuals regain their eligibility, it is anticipated that the ALOS will decrease slightly in Q3 and Q4 '18.

As the members' acuity increase, providers are looking to other places outside of the acute unit for members to further stabilize. The Intermediate Duration Acute Psychiatric Care and the State inpatient beds are being sought after to provide this additional stabilization out of the community. Additionally, some inpatient providers are establishing relationships with shelters.

Recommendation 1: Continue Adult Inpatient PAR Program
Regional Network Managers continued to conduct Provider Analysis and Reporting (PAR) meetings with the adult inpatient psychiatric hospitals during Q1 and Q2 2018. Clinical and Medical Affairs staff from Beacon are able to participate in PAR discussions as needed. These conversations provide an important forum to understand the varied clinical philosophies, community resources, treatment approaches, and cultural influences at each hospital and within each community. Understanding a provider's performance within this context furthers our ability to shape provider practice via the PAR program.

The realignment of hospital systems into larger networks is shifting the provider landscape with increasing effect across the healthcare system. This evolving phenomenon has added a new dimension to how PAR data is analyzed, prepared, and presented by Beacon. Ensuing discussions related to ALOS and other metrics are no longer singular in content, but inclusive of how a particular hospital acculturates to a larger system of care.

There continues to be notable variation across the network in regards to ALOS and readmission rates. Frequently PAR discussions focused on barriers and best practices for achieving and/or maintaining an efficient length of stay while maintaining low readmission rates. Hospitals continue to identify the following barriers influencing ALOS and/or readmission rates: staffing shortages across disciplines, breakdown in adherence to treatment protocols, timely access to state, intermediate and residential beds, homelessness, probate hearings, ECT, and geriatric and schizophrenia populations.

In addition to reviewing data, PAR meetings and statewide workgroups were utilized to promote new and existing initiatives and best practices. For example, a new measure was added to the PAR profile related to prescriptions filled post discharge. In light of this PAR data and analysis of system-wide performance on HEDIS measures related to antidepressant and anti-psychotic medication management, a focus of the adult inpatient workgroup and subsequent PAR meetings has been best practices for medication adherence. This measure also prompted discussion related to evidenced-based practices for dually diagnosed members, as filled prescriptions for Medication Assisted Treatment (MAT) post discharge were relatively low. Beacon encouraged hospitals to provide MAT education, consider MAT induction where appropriate, and provide scripts for Narcan upon discharge to members with an Opioid Use Disorder. These best practices compliment the activity that is occurring at various Emergency Departments and Freestanding Detox/Withdrawal Management facilities across the state.

Additionally, there is emerging interest across many hospitals in social determinants of health. For example, several hospitals have expressed interest in establishing relationships with housing/shelter providers modeled after Yale's partnerships with Columbus House (Medical Respite) and Continuum (Community Transitional Services Step Down). Beacon plans to invite Yale to present on their innovative housing programs at the next adult inpatient workgroup this fall/winter. The RNMs are also supporting connections to community-based organizations where appropriate.

Recommendation 2: Modify Inpatient Bypass Program
During the first half of 2018, Beacon began to reevaluate the inpatient bypass program. Based on provider feedback and available resources, it was decided that case mixing as it relates to average length of stay would be initiated. Internal discussions were held to begin identifying possible variables to enter into the predictive model. A small provider workgroup was held in July to brainstorm potential indicators and methodology. All of the selected variables will be tested to determine if they have an impact on length of stay. A follow-up workgroup will be held with the providers and state partners in the fall to review the results of the analysis and to identify the variables with the most impact.

Inpatient Detoxification – Hospital Utilization
Discharge volume overall increased from CY '16 to CY '17 for hospital-based inpatient detoxification despite a quarterly decline from Q2 '17 to a recent low of 758 discharges in Q1 '18. The second quarter of 2018 experienced a large increase of 23% to 930 discharges.

Over 80% of discharges from hospital-based inpatient detoxification continue to be HUSKY D members. The increase in discharge volume from Q1 '18 to Q2 '18 was driven by an increase in HUSKY D members discharging from hospital-based inpatient detoxification during this period. While small in number, HUSKY A and HUSKY C members utilized inpatient detox at the same volume in the most recent quarter, each accounting for 8% of the discharges in Q2 '18. Overall, the hospital-based inpatient detoxification discharges are predominantly male (73% of discharges) and in the age group 45-54 years old (36% of discharges).

Due to detoxification protocols, the quarterly ALOS remained steady with minimal variation from the 10-quarter average of 5.3 days. The ALOS was 5.3 days in Q1'18 and 5.5 days in Q2 '18. ALOS varies the most by age group with the 45-54 year olds and the 55-64 year olds having a longer hospital-based detoxification stay.

Hospitals with greater than 10 discharges in the past two quarters ranged from an ALOS of 4.1 days (St. Francis) to 6.3 days (Johnson Memorial Hospital) in Q1 '18. The range was larger in Q2 '18 from 3.8 days (Stamford Hospital) to 7.8 days (William Backus Hospital). In fact, there were three (3) providers in Q2 '18 with an ALOS greater than seven (7) days: William Backus (7.8 days), Middlesex Hospital (7.3 days), and Danbury Hospital (7.2 days). It is important to note that most hospitals providing inpatient detoxification do not complete the discharge form and therefore members may have been discharged prior to the last date Beacon has on file, which could reduce the average length of stay in some of the hospitals noted above.

From the data shared in the Provider Analysis and Reporting (PAR) Program, the total 7-day readmission rates for all in-state detoxification providers – hospital based (excluding state facilities) for Q3 and Q4 '17 reached a high of 10.0%, but decreased to 8.4% in Q1 and Q2 '18. The 30-day readmission rate continues to be high but stable at 28% for both Q3 and Q4 '17 and Q1 and Q2 '18.

Recommendation 3: Continue Hospital-based Detoxification PAR Program with high-volume facilities Moving forward, as mutually agreed upon with the state partners, Beacon will target the high-volume facilities such as Yale and St. Francis, which account for approximately 36% of discharges statewide. Meetings with lower volume facilities will be held only if indicated by their performance on the PAR measures and/or quality of care concerns. A continued focus of the discussions with high-volume hospital based detox providers will be on increasing utilization of Medication Assisted Treatment (MAT) for both Alcohol Use Disorder (AUD) and Opioid Use Disorder (OUD).

Recommendation 4: Continue to Provide Education to Providers
The Clinical Supervisors, Clinical Care Managers (CCMs), and Co-Management CCMs continue to provide case consultation and differential diagnosis support to all hospital-based detoxification providers in determining which Administrative Service Organization (ASO) is the correct ASO to authorize this level of care. In Q1 and Q2 2018, Beacon hosted webinars and invited all inpatient and residential rehabilitation providers to learn how to complete the discharge form and set Health Alerts for appointments, medication and filling prescription reminders. Unfortunately, these webinars were not well attended so Beacon continues to work with providers, particularly St. Francis and Yale, to complete the discharge forms timely to ensure accuracy in ALOS and appropriate discharge planning.

Inpatient Detoxification – Freestanding Utilization Discharge volume for inpatient detoxification in a freestanding facility has been unchanged the past three quarters from Q4 '17 through Q2 '18 at around 2,800 quarterly discharges. Consistent with the other inpatient levels of care and across the past 10 quarters, freestanding inpatient detoxification discharges were mostly HUSKY D members (85% of discharges. HUSKY A was the next highest benefit group at 11% of discharges in Q2 '18. The majority of the discharges were males (71%), while the age group of 25-34-years-olds comprised the largest percent of discharges (38%).The demographics for discharges show minimal changes year over year.

The ALOS was stable over the last 10 quarters. The ALOS in Q1 was 4.3 and 4.2 in Q2 '18. Men and women continue to have the same ALOS because this treatment is protocol driven. Aside from the few discharges ages 65+ with a higher-than-average length of stay, the next two age groups (45-54 and 55-64) had an ALOS of 4.4 and 4.5 days, respectively in Q2 '18. The young age population, ages 18-24 tends to have the lowest ALOS at 4.1 and 3.9 days in Q1 and Q2 '18. The 18-24 year-olds do have the highest AMA (leaving Against Medical Advice) rate for Q1 and Q2 '18 combined at 22.1%, which may be a factor in the low length of stay. The overall AMA rate for all discharges was 18.7%. Discharges that had a primary opioid use disorder diagnosis had a higher AMA rate (24%) than discharges with a primary alcohol use disorder diagnosis (15%).

There are seven (7) inpatient freestanding detox providers that produce approximately 2,800 discharges comprising of 2,300 unique members each quarter. Intercommunity, the largest provider, treated 25% of all discharges in Q2 '18, similar to prior quarters. Because treatment is protocol driven, there is little variance among providers for ALOS. ALOS ranged in Q1 '18 from 3.7 days at Cornell Scott-Hill Health to 4.8 days at Stonington Behavioral Health. In Q2 '18, the range was from Intercommunity Recovery Center at 3.5 days to 4.9 days at MCCA and Stonington Behavioral Health.

From the data shared in the Provider Analysis and Reporting (PAR) Program, the total readmission rates for all in-state freestanding detoxification providers had increased from CY 2016 to CY 2017. The semiannual 7-day readmission rate was 5.0% for Q3 and Q4 '17 and remained stable at 5.1% for Q1 and Q2 '18. Over time, the 7-day readmission rate has been increasing. The 30-day readmission rate has been stable at 19% for both Q3 and Q4 '17 and Q1 and Q2 '18. The majority of discharges (77% of 7-day readmissions and 61% of 30-day readmissions) are readmitting to a different provider.

Due to the ongoing opioid epidemic, Beacon has been developing various reports and dashboards that explore and target the population of members affected by opioid use. In the coming months, Beacon expects to weave together various reports into a dashboard that will help us identify what the opioid-using member population looks like, who is at the most risk for incidents such as overdose, and where there may be opportunities for intervention.

Recommendation 5: Continue Provider Workgroup Meetings and PAR Program
In Q1 and Q2 '18, Beacon continued to meet with the withdrawal management facilities to engage in discussions about the PAR measures of ALOS, readmissions, AMA rates, discharge form completion, and connect-to-care rates.

A specific area of focus this PAR cycle was a targeted discussion about Medication Assisted Treatment (MAT). With Connecticut surpassing the national rate for drug and opioid overdose deaths, every withdrawal management provider was asked to identify the current barriers, which stand in the way of offering induction on MAT with a warm hand-off rather than detoxifying via a traditional taper to zero. With research and data to support this needed shift in treatment philosophy of OUD, many providers have started to take steps towards operationalizing warm hand-offs post detox episodes with local outpatient MAT providers and some are already inducting on MAT due to rapid access available within their own continuum.

Stonington Institute is a good example of a withdrawal management provider who, after this most recent PAR cycle, identified an opportunity to make changes to their existing buprenorphine opioid detox protocol to be able to offer an induction versus a taper when clinically appropriate. While the seven in-state withdrawal management facilities all vary in terms of fully adopting MAT induction practices, there appears to be a consistent commitment across the provider network to continue working towards this shift in practice.

To further support standardization of comprehensive MAT education and induction while in the 3.7 withdrawal management LOC, Beacon, DSS, and DMHAS have partnered with two centrally located providers, InterCommunity and Rushford, to engage in a pilot. The goal of the Changing Pathways Pilot is to "change pathways" to recovery for the OUD cohort from a taper-to-zero protocol to induction on one of three evidence-based MAT options, i.e. buprenorphine, methadone or naltrexone, with a seamless transition from inpatient withdrawal management/detox to outpatient MAT.

While in the short-term efforts will be focused on these two pilot providers, the long-term goal is to disseminate a best practices/lessons learned toolkit to the remaining withdrawal management providers coupled with the development and monitoring of various MAT metrics to be able to track progress. This will be the focus of Beacon's next statewide workgroup. This initiative will be reviewed in detail within our Performance Target summary.

Home Health Utilization
After a drop in the number of authorization initiations (admissions) that occurred between Q3 '17 and Q4 '17, admissions for Medication Administration for all members including duals has remained stable for the past three (3) quarters. The HUSKY C (ABD/Other Dual) members' admissions had consistently been higher than other benefit groups until the aforementioned decrease that occurred in Q4 '17. Since that time, HUSKY D members have had the highest volume of Medication Administration admissions.

During the first two quarters of 2018 combined, HUSKY D 25-34 year olds had the most admissions of all the age group and benefit group combinations, which is a shift in the population receiving this service which had been largely HUSKY C and those that were 55-64 year olds. Beacon will review if this shift continues at the annual utilization submission. HUSKY C (ABD Single) continues to have the highest admits per 1,000 each quarter.

Start of Care/Resumption of Care authorizations continue to replace Skilled Nursing authorizations. The use of a Skilled Nursing visit is now limited to a once weekly pre-pour of medications, in home wound care for members receiving behavioral health services, or a full nursing assessment in the event of a change in condition. The utilization for the Start of Care/Resumption of Care has leveled off in Q1 and Q2 '18 after a spike in utilization in Q4 '17. Since Skilled Nursing and Start of Care/Resumption of Care are authorized in conjunction with Medication Administration, the trends by benefit and age group are the same as for Medication Administration.

Home Health Prompting, Home Health Aide, Med Box and Med Tech requests for new authorizations have been exceptionally low with only one or two admissions each quarter, if any. Med Box and Med Tech services are often utilized through the medical ASO and/or the waiver programs.

Recommendation 6: Continue Home Health Bypass Program
Beacon continued the Bypass and Bypass Plus Program for home health agencies in 2018. The Bypass Program provides administrative relief for home health agencies while promoting practice change that will benefit members and improve the efficiency of Home Health services. The agencies on bypass are authorized for longer periods of time, thus decreasing the number of concurrent reviews required for an episode of care. The Bypass Program eligibility criteria continues to be achievement of a BID medication administration target rate and emergency department rate.

The Home Health Bypass programs continue to demonstrate positive results, with Q3 '17 BID statewide average of 10.4%, an all-time low. All but five (5) of the 21 bypass-eligible providers met the ED target rate of 32% or lower. Beacon continued to work and collaborate with providers to achieve the bypass goals by regularly reviewing and monitoring their status and discussing the tools to support the reduction of the BID rate.

Beacon continues to review opportunities to enhance the Bypass Program parameters to further incentivize agencies to decrease member reliance on homecare services. Suggested changes involving auto-approval of initial authorizations will be presented to providers in Q4 '18 with a plan to go-live after the first of the year.

Lower Level of Care Utilization
Outpatient admissions continued to increase from Q4 '17 to Q1 '18 (up 6.6%) and then remained flat from Q1 to Q2 '18 at approximately 30,000 admissions per quarter. The rate of increase was slightly lower in CY '17 (8% increase) as compared with CY '16 (17% increase). Partial Hospital (PHP) and Intensive Outpatient (IOP) treatment have been slightly increasing over time, whereas Methadone Maintenance has been on a steady decline to a 10-quarter low in Q2 '18 despite an expected increase in demand associated with the opioid crisis. IOP has been slowly increasing due to new SUD IOP programs such as Hartford Dispensary which opened multiple sites statewide. In Q2 '18, IOP admissions reached a 10-quarter high at 5,037 admissions. Many providers are utilizing their own internal IOP more frequently instead of other restrictive levels of care like residential.

Enhanced Care Clinics (ECCs)
The total non-ECC registration volume (inclusive of both adults and youth) continues to steadily increase over time, while the total ECC volume has been on a slight decline. ECC volume has decreased by over a thousand registrations between Q1 '17 (5,698 registrations) and Q2 '18 (4,519 registrations). Q2 '18 was a 10-quarter low for ECC registrations. Non-ECC registrations are now approximately 89% of all outpatient registrations. While adult ECC volume had been on the decline for many quarters, after a low in Q4 '17 registration volume increased in Q1 by 5.8% and remained stable in Q2 '18 at 2,328 registrations.

The routine and emergent access standards have consistently been met each quarter, while the urgent access standard has had variability between meeting and not meeting the 95% access standard. The urgent standard was not met in Q4 '17 (91.7% access) or Q1 '18 (93.6% access), but was met in Q2 '18 at 100% access.

Recommendation 7: Assess ECC initiative Over the past several months, there were many meetings held to discuss an ECC Redesign that addresses the operationalization of ECC program metrics, incorporation of value based payment methodologies, and opportunities to broaden the initiative. These meetings remain ongoing. Feedback to members of the Operations Subcommittee on the progress being made around these discussions is scheduled for Friday September 7, 2018.